The Compensable Injury

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■ *The complexities and interferences in the doctor-patient relationship during the treatment of the compensably-injured workman create an unusually high incidence of delayed recovery, complications, and permanent disability. Many persons, once injured, never return to economic self-sufficiency. Among the factors that may have a bearing in producing this situation are: The psychological context of the injury itself; the personality of the patient; the "reverse incentive" created by reward for illness; third-party interference from attorneys, insurance claims adjusters, and union representatives; consequent hostility of the patient toward a doctor he usually has not chosen; and, too often, hostility of the physician toward his patient. Iatrogenic complications may also be present when ill-advised surgical procedures are used in the presence of psychological complications.*

To improve the situation the adversary system should be removed and outside interferences in treatment should be reduced. Physicians treating patients in such circumstances should learn more about psychiatric diagnosis and management. They should give more attention to remotivation and rehabilitation.

A PATIENT WITH AN accidental injury which makes him eligible for compensation enters a strange and complicated world unlike the corresponding environs of patients of any other type. Attorneys, claims agents and even labor union representatives and judges may have an influential role in the diagnosis and the treatment of his condition. The motivation of the patient is significantly altered and in most instances the attitude of the physician toward the patient is significantly different than toward the average patient. Small wonder, then, that in such cases there is an inordinately high incidence of complications, of delayed recovery and of permanent disability. The aim of this paper will be to examine some of the complexities of the compensable injury problem that create these complications.

In 1963 Nemiah[2] wrote:

"For most people the enforced dependency of a disabling physical disorder causes no serious difficulty. They are able to accept the dependency and help from other people as a necessary means to recovery, and when the functioning of their physical bodies has returned to its fullest possible capacity, they easily give up their dependent state and return to their habitual adult behavior of activity and self-reliance. There is, however, a group of people who have major emotional conflicts centered around their dependency needs."

Nemiah went on to say that these patients have a great tendency to develop an exaggerated and prolonged pattern of dependency, centered around

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physical complaints, that prevents their return to activity and productive work even when the physical functioning of their bodies has been restored. These are the patients whose disabilities and complaints far exceed the limits one would expect from the findings on physical and laboratory examination. "They appear unduly incapacitated and dependent, make excessive demands on doctors, nurses and family for the smallest service, and become angry, critical and demanding when their wants are not fulfilled." Very often these patients are characterized by a tendency to see themselves as strong, active and self-reliant; transferring the responsibility for their incapacity to the offending organ or the symptoms. These are patients who have had conflicts between wishing to be independent and self-sufficient on the one hand and wishing to be cared for and looked after, on the other; and who have tried to resolve these conflicts by over-reaction in the direction of hard work in an effort to maintain a feeling of independence, an uneasy and unstable solution that has now broken down.

Hirschfeld and Behan,[1] writing in 1963 on "The Accident Process," said that before most accidents occur there is a state of conflict and anxiety within the patient. They studied a number of patients injured on the job in the automotive industry, and came to the conclusion that this conflict and anxiety produces a significantly large number of accidents in the following way: As a result of his emotional condition, the worker finds a self-destructive, injury-producing act, following which he then becomes engaged in going from doctor to doctor for help, thus avoiding the true sources of his original conflict. In other words, an unacceptable problem has been converted into a problem that is acceptable to the patient by virtue of his injury. Hirschfeld and Behan concluded that most accidents are a single event in a continuing dynamic process. The beginning of this process is the state of conflict, tension or anxiety before the event, followed by the catastrophic event itself, and then the new way of life as a patient with an escape from the old conflicts. They found a number of instances in which skilled workers in a state of emotional turmoil made mistakes which a novice would never make. Their conclusion was that the chief difficulty in helping these patients stems from these facts: (1) They are solving life problems through their symptoms, and (2) the symptoms guarantee a legal incapacity which will provide for their continued support.

There appear to be five classes of persons in whom psychiatric complications are most likely to develop when they incur an injury in which compensation is involved. These are:

1. *The hysteric.* There are persons who use avoidance and denial techniques to modify painful reality and who try to block conscious recognition of unacceptable feelings, of impulses and of conflicts, with variable success. Although they maintain some reasonable participation in interpersonal activities, they are incapable of great emotional depth in their relationships with others, making special demands on others in their relationships. They may appear to be warm and responsive, but this warmth is usually found to be superficial and insincere when examined more closely as these patients are quite egocentric and manipulative in their relationships with other people. They are people who make great demands on others and use their symptoms to control the lives of the people upon whom they feel dependent. These are the patients who are most likely to have conversion reactions with non-anatomical paralyses or anesthesias or with excessively widespread disabilities after rather minimal to moderate injuries.

2. *The dependent and immature.* There are persons in their adult years who have never "grown up." Dependent on others and virtually incapable of accepting the responsibility for themselves, they avoid situations which impose responsibility upon them. Their relationships are generally characterized by a clinging quality and by the fact that they openly seek, and tend to find, others who will "take care of them." They often have a history of repeated job changes and of rather brief periods of time spent at any one job. Often they do not marry but continue to remain in the parental home well into adulthood. If they are married, it is usually the spouse who is the strong member of the family. These are persons who, once injured, will settle for a relatively low level of economic subsistence, the injury having provided a concrete "physical" reason to explain their total dependency and lack of ability to take responsibility for themselves.

3. *The over-conscientious hard worker struggling with conflicts over independence and self-sufficiency.* Persons of this order can be considered to have always been one step ahead of their wishes to be dependent and to be cared for by others; who were incapable of accepting such behavior on their own part, and, therefore, worked overly hard

and overly long, resenting it all the while. Once they are injured, they become very much like persons of the type described in Group 2, while protesting that they are active and self-reliant but are prevented from behaving that way by their physical disability.

4. *The depressed patient.* Depression has a twofold effect in increasing the proneness to injury. For one thing, depressed patients often have nearly-conscious or conscious desires to injure themselves, even to kill themselves. They will often quasi-consciously injure themselves in the grip of such self-destructive impulses. Other qualities of the depressed patient are decreased vigilance, attention turned away from the world and inward on the self, reduced psychomotor activity and diminished coordination—all of which make them exceptionally prone to accidents in situations where vigilance and coordination are required. With these patients, the depression is a serious complicating factor in rehabilitation and must be attended to if rehabilitation is to be successful.

5. *The sociopathic exploiter.* The sociopathic person is one who has been unable to assimilate a consistent set of ethical values. His major values are self-seeking ones, and society is viewed as an adversary to be circumvented. The "sociopath" may conform to regulations and laws for much of his life, the responses based on a short range view of immediate consequences rather than any stable set of internal values. When such a person is in a position to manipulate others to his own advantage, as in the instance of an industrial injury, the possibility of economic gain becomes a powerful motive to use dishonest means and to misrepresent his degree of disability. It is in this group that malingering is most often seen. Such persons may appear to have a certain charm, especially if they feel that it is to their advantage to display it. Examination of their history will show a consistent inability to manage relationships with authority figures, frequent job changes, few or no lasting relationships and a history of "using" others to their own advantage.

A complicating factor in every case of industrial injury is the fact that there is an element of reward for illness which militates against the patient's giving up the sick role. In addition, in our litigation-conscious society, the industrially injured patient will frequently consult an attorney before or very soon after, he consults his physician. Thus, almost from the outset, there is a more complicated physician-patient relationship with third party interference than in any other kind of illness. This does not increase the physician's motivation to work with this patient. Some physicians work with such patients only out of a feeling of obligation, which makes them less interested in their industrial injury patients than in any other patient they have. Some physicians feel a great deal of hostility toward the industrial accident patient, and behave as though all such patients were all malingerers and exploiters. For one thing, the care of these patients is considerably less rewarding financially; they are more difficult to treat; and the prognosis is always poorer than with the private patient.

This hostility is matched by the hostility of the patient who does not trust the physician who is paid by the insurance company rather than by him. Each then reacts to the resentment and hostility of the other, which effectively poisons the physician-patient relationship.[3]

The contest atmosphere further complicates the relationship, with both patient and physician being cautious, defensive, suspicious of each other and frequently having their relationship interrupted by court order or by unexpected changes in examining physician arranged by the insurance company or demanded by the patient's attorney.

Finally, the iatrogenic complications themselves complete the compound. Many a patient whose injury has physically cleared up but who for various psychological reasons continues to feel pain and suffers disability, is given braces, or even has surgical procedures performed on him to produce "stability" in a given joint, with a further fixing of symptoms; even developing new disabilities as a result of the surgical procedures. The end result is a medical and psychiatric chaos unlike anything else in medicine.

There is an increasing body of opinion that favors a change in our present system of handling, diagnosing, treating and compensating patients with industrial injuries. It is difficult to see how psychiatric and psychological complications of the compensable injury, as they now occur, can be reduced in frequency until the following changes are brought about:

- Removal of the adversary or contest system from the management of industrial injuries.
- An increased responsibility of the physician toward his patient and an assumption of his proper role as the doctor in charge of the care of his patient, without interference from outside parties.

• An increased awareness on the part of the physician of the psychological factors that predispose to the occurrence of injuries and to the psychiatric complications of injuries. This would include the ability to diagnose and differentiate the hysterical patient from the one with dependency conflicts and to be able to recognize the depressed patient and the "sociopath."

• An increased attention of the physician toward *remotivation,* using the support inherent in the physician-patient relationship to reestablish the patient's desire to care for himself and to reassume his personal and social responsibilities.

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